Texas Osteopathic Physicians Journal

VOLUME XXIV FORT WORTH, TEXAS OCTOBER, 1967 NUMBER 6

In This Issue—

Texas Osteopathic Physicians' Journal

OFFICIAL PUBLICATION OF THE
TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS

PUBLICATION OFFICE: 512 BAILEY AVE. FORT WORTH, TEXAS 76107

VOLUME XXIV FORT WORTH, TEXAS, OCTOBER, 1967 NUMBER 6

The Washington Newsletter

The Washington Office of the American Osteopathic Association is actively studying the Department of Defense Armed Forces Physicians' Appointment and Residency Consideration Program (The Berry Plan) and programs of the individual military services for the procurement of physicians. At the moment, osteopathic physicians are not eligible to participate in the "Berry Plan" and therefore find it more difficult to be deferred to complete residency training.

Less than one-half of the M.D.'s who apply are selected to participate in the plan and the total number depends, in part, on the projected requirements of the military services for the various specialists. It is anticipated that D.O.'s will be included in the Berry Plan and other programs, in the near future on the same basis as M.D.'s.

The application period for the Berry Plan for 1967 graduates ended August 1, 1967, so the 1968 classes are the ones which may become eligible. Because the plan is not well understood by many, and in some instances misunderstood, excerpts from the Berry Plan are presented below.

"1. *The Program*

A. The Armed Forces Physician's Appointment and Residency Consideration Program (Berry Plan) has a two-fold purpose. It provides a means by which:

1. Physicians who are liable for active duty may volunteer for a Reserve Commission in one of the Military Services and may be brought to duty as an officer at a time mutually acceptable to the individual and the service concerned.

2. The Army, Navy and Air Force may obtain volunteer general duty medical officers and specialists.

To fill the Services' projected requirements for specialists, the Department of Defense will sponsor the deferment of a selected number of interns who will be permitted to complete residency training before being called to active duty. This program was developed with the cooperation of the Director, Selective Service System.

B. No additional military service is required as a result of participation in this program. Participants who are called to active duty through it will be required to serve 24 months, the period for which they are obligated under the Universal Military Training and Service Act, as amended.

C. Between July 1, 1968 and June 30, 1969, the Department of Defense will have an extensive requirement for general duty medical officers to fill positions vacated by personnel who will be completing 2-year tours of duty or who will be leaving the service for other reasons. It is hoped that the requirements of the Services can be met by voluntary programs such as this one. However, if an insufficient number of volunteers enter the program, special draft calls must be placed with the Selective Service System to meet the deficit. Physicians who wait for a draft call must be prepared to enter military service at the time of the call, even though in practice or residency training. Those who apply for a Reserve commission after having been ordered for induction by Selective Service will not have a choice of Service and will not be able to select the time of their entry on active duty.

D. *Those physicians who are 1967 medical school graduates who do not wish to subject themselves to the uncertainty of the draft are offered through this program, a Reserve commission and one of the following choices:*

1. *Active duty immediately upon completion of internship (post-internship duty);*

(Continued on Page 4)

EDITORIAL PAGE

Good But Not Enough

GEORGE W. NORTHUP, D.O.,
Editor, American Osteopathic Association

The 1967 osteopathic Christmas Seal season is here. This is one of the ways you individually can contribute to the future of our profession.

Each year the Christmas Seal Program increases in its receipts. The goal for 1967 is $150,000, to be divided evenly between student loans and osteopathic research. Yet, the negative side of the program still exists. Only one quarter of practicing osteopathic physicians make any contribution to the program. The quarter of the profession that does contribute produces results that are nothing short of phenomenal. But think what the results would be if another quarter joined the efforts of those already contributing.

To those who have contributed and worked in the past, we urge even greater effort. Actually, your personal contribution to this program and the contributions made by your patients and friends represent an investment in *you*. Because osteopathic education is benefited through student loans and osteopathic practice is benefited through osteopathic research, you and your patients are the ultimate recipients.

It is hard to believe that there are thousands of public dollars, waiting to be contributed to this program, which are lost each year because of the apathy of some D.O.s. We must reach these potential investors in osteopathic medicine, merely by giving them the invitation and opportunity to give.

Osteopathic physicians who donate these tax-deductible dollars and provide their patients and friends with the opportunity to do the same realize that it can be done with little effort. Several osteopathic physicians, with average practices, have delivered well over a thousand dollars per practice toward the success of this program. The public has demonstrated its willingness to help. We must demonstrate our willingness to act.

Nineteen sixty-seven must go down in history as a "good year" for the osteopathic Christmas Seal program. You can make it so. Give! And give others the privilege of giving!

DON'T WAIT

On Saturday, November 4th mail out your Seal "packets" to patients, friends and tradesmen. Give them a chance to say "thanks" to the profession before they're hit with the myriad distractions of the Christmas rush!

As in the past, the $150,000 set as a goal for this year's Osteopathic Christmas Seal Campaign will serve a two-fold purpose—the expansion of the profession's Research programs and the enlargement of a Student Loan program that is perhaps the soundest immediate answer to the osteopathic student dropout problem.

Your profession needs your help—and needs it NOW! It's as easy as it is essential that you do your part by sending out those "packets" ON TIME.

AUXILIARY MAIL CLERK SERVICE—Busy doctors can get help from "Mail Clerk Service" offered by the auxiliary. Mrs. Hillard says "These ladies in your community will be more than willing to assist you if you furnish them with your mailing list and cover the postage costs. They will also keep the records of contributions for you, mail the acknowledgment cards to donors and give you a full accounting at the end of the campaign."

(Continued from Page 1)

2. *Active duty as late as one year following completion of internship (delayed duty);*

3. *An opportunity to be selected for deferment for residency training in specialties required by the Armed Forces.*

"II. *QUALIFICATIONS*

For commissioning and call to duty, or residency deferment consideration, participants must meet *all* of the following requirements:

A. Be a *1967* graduate of a medical school which meets the criteria of the Council on Medical Education of the American Medical Association, or possess an Education Council for Foreign Medical Graduates (ECFMG) standard certificate." *Regarding off-term graduates, "physicians who will be graduated in September or December 1967 will not be eligible for this program, but may participate in the 1968 program. The reason is that the rosters furnished by the Deans of the medical schools are compiled in March and include only the names of those to be graduated during the current school year.* The names of the students who will be graduated the following September or December would not be included on that roster.

B. Be liable for two years of active military service under the Universal Military Training and Service Act;

C. Be willing to apply for, and if qualified, accept a Reserve commission in the medical corps of the Army, Navy or Air Force."

The Department of Defense and Congress are now considering several legislative proposals designed to attract and *retain physicians* in the Army, Navy, and Air Force. We expect that D.O.'s will be permitted to participate fully in any new programs.

ROY D. HARVEY, D.O.
Director

KCOS Fall Term Begins

Registration of students at the Kirksville College of Osteopathy and Surgery closed with a special orientation program for first-year enrollees on Saturday. Dean of Students F. M. Walter announced that 395 will be attending the KCOS this year. The figure includes 106 in the first-year class, 104 in second year, 90 in third year, and 95 in the fourth year. The total enrollment remains the same as last year.

The incoming class, representing 27 states and the District of Columbia, includes three ladies, the same number as in 1966-67. Forty of the freshmen are married and sixty-six are single, reflecting about the same ratio as in past years.

Throughout the registration period, first-year students and their families have been the guests of KCOS social and service fraternities at open houses, socializers, and other activities. Freshmen wives were also entertained by the Student Wives Auxiliary on Sunday afternoon.

Classwork at the osteopathic college began at 8:00 a.m. on September 11.

Arizona Osteopathic Medical Association

The central office of the Arizona Osteopathic Medical Association is now established in the first building ever owned by this association located at:

5057 East Thomas Road
Phoenix, Arizona 85018
New Phone: 959-0460.

The new building is a single story structure containing three offices, one large lobby — meeting room, one smaller executive meeting room and a small kitchen. There is a large walled in paved parking area and the grounds have been landscaped in a desert theme with cactus and volcanic rock.

"foodoholic"?

It may be a fact "that most persons who regularly overeat . . . eat compulsively much as the alcoholic person drinks compulsively." —Modell, W.: J.A.M.A. *173*(10):1131.

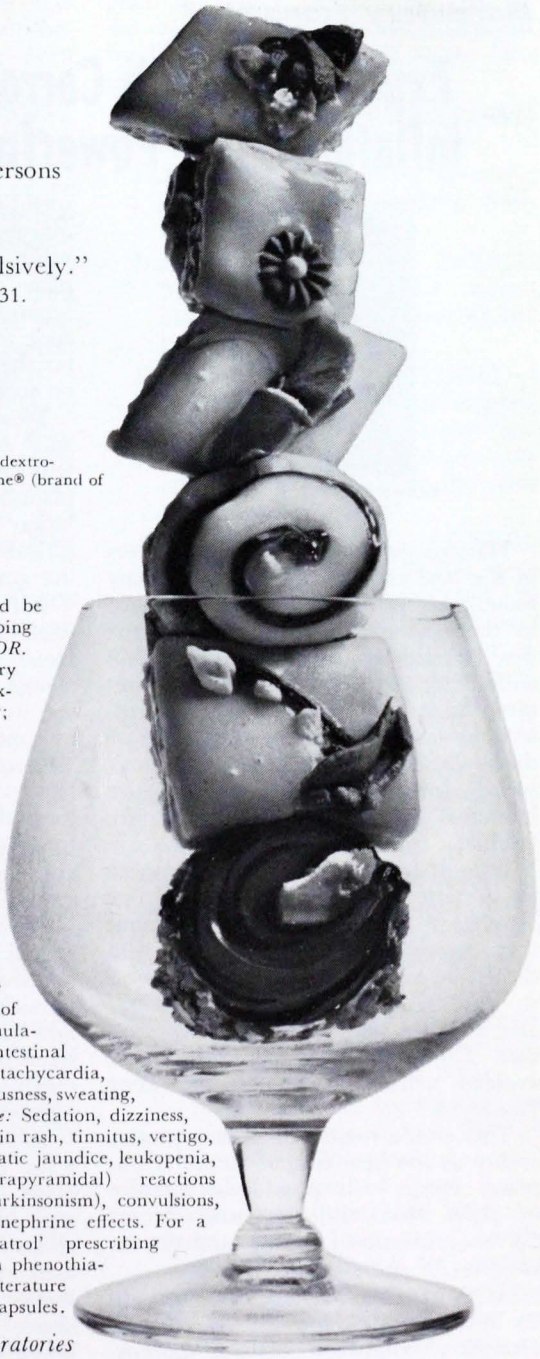
Start overweight compulsive eaters on ESKATROL®

Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules



Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. The following is a brief precautionary statement. *Contraindications:* Hyperexcitability, undue restlessness, anxiety; hyperthyroidism; lactating (nursing) mothers. Do not use in patients taking MAO inhibitors. *Precautions:* Use in pregnant patients only when deemed essential for the welfare of the patient. Phenothiazines may potentiate central nervous system depressants. Use with caution in hypertension and coronary artery disease. Excessive use of amphetamines by unstable individuals may result in a psychological dependence. *Side Effects:* The following are unwanted reactions reported or considered possible with the components of 'Eskatrol'. *Dextroamphetamine:* Overstimulation, restlessness, insomnia, gastrointestinal disturbance, diarrhea, palpitation, tachycardia, elevation of blood pressure, tremor, nervousness, sweating, impotence and headache. *Prochlorperazine:* Sedation, dizziness, hypotension, tachycardia, dry mouth, skin rash, tinnitus, vertigo, nasal congestion, miosis, lethargy, cholestatic jaundice, leukopenia, agranulocytosis, neuromuscular (extrapyramidal) reactions (motor restlessness, dystonias, pseudo-parkinsonism), convulsions, catatonic-like reactions, reversal of epinephrine effects. For a comprehensive presentation of 'Eskatrol' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*. *How Supplied:* Bottles of 50 capsules.

SK&F *Smith Kline & French Laboratories*

Mandatory Economics?

Expanded Keogh Carrott and Surtax Inflation Stick Powerfully Motivating

ROBERT B. PRICE, C.P.A.
Executive Secretary

Management and economics observers of the professional scene have for many months been evaluating the importance to the doctor and his family of the new latitudes available January 1, 1968 within the tax-deductible Keogh retirement plans. A totally new element, income surtax, plus the groundswell of the speed-up of inflation, are motivating virtually every doctor to consider how real these special advantages are for him.

It is a truism that the government doesn't tax you on what you earn, your income; it taxes you on how you spend that income. Before Keogh, if you earned some money you paid taxes on it. And if you invested that money and it had earnings, you paid taxes on that. This double-taxation now can be avoided within the Keogh law after January 1.

This escape route will assume greater reality as the new federal surtax is imposed for it will provide a measure of relief from the composite income tax on professional income and on the earnings of the plan's securities.

A third form of taxation making its effects insidiously felt is the inflationary outgrowth of our government's fiscal policies and tremendous spending programs. Inflation places an invisible tax on every dollar of present value that people have, and Keogh plan cumulative earnings provide a superior hedge against loss of capital and reduced incomes because of the tax-shelter extended to the accumulation on such earnings.

Most analysts agree that both a surtax and an increasing inflationary trend will be long-term factors which require planning if the doctor is to avoid dilution of his earnings, accumulate significant funds and preserve them for the goals of himself and his family.

Between 1962, when the original "Self-Employed Individuals Tax Retirement Act" was passed, known as the Keogh bill because its prominent sponsor was Representative Eugene Keogh, up until the present time only about 12% of the country's eligible physicians have signed up. Many held back because the initial legislation placed severe limitations on the tax deductions available to a doctor establishing his own retirement plan. Now these have been liberalized so that the new amendment signed into law will actually double the tax deduction available to the individual physician. Observers agree that from now on practically every doctor will stand to benefit from setting up a plan, regardless of age, income, family or number of employees.

Even under the earlier, limited privileges of the basic Keogh legislation, often derided as "half a loaf," many state and national professional associations developed plans which effectively used the leverage of the partial tax shelter. One of the earliest was Tennessee Medical Association, closely followed by Florida Medical Association. Because the most significant advantage

of the Keogh philosophy is the tax-sheltered position of capital contributions, outstanding results have been recorded by those mutual funds that emphasize capital appreciation. Adding to this advantage is the fact that a mutual fund application of Keogh planning allows a greater portion of the doctors payments to be at work for him during the early years of the program because the creation and sales charges are spread evenly throughout the term of years rather than in the first year of purchase as is the cause in general types of systematic investment plans.

In identifying the upper and lower limits within which the potential goals of present-day Keogh plans are to be found, it will be useful to approximate the average situation of a D.O. in a 28% tax bracket for taxable years after 31 Dec 67, at $2,500 annually:

WITHOUT KEOGH—only $1,800 per year available for investment, would aggregate $64,603 in 25 years at 4% maximum safety bonds.

WITH KEOGH, in a "balance" mutual fund performing at 6% compounded annually, a total aggregate of $156,150

WITH KEOGH, in an average-performance capital appreciation fund and assuming economic levels only moderate throghout the 25 years, investments and accumulations could exceed $233,769.

The impact is even more significant upon realizing that $2,500 anually for 25 years amounts to an average investment of $31,250 over that time span. Our D.O. in the example is buying these programs at a twenty-eight per cent discount (28%) inasmuch as he is getting a $2,500 investment each year through the expenditure of only $1,800 additional monies.

For doctors in higher tax brackets, or for those in lower tax brackets as the surtax law moves toward implementation, the performance profile of Keogh plans is of even greater importance to the doctor who wants something left for himself and his family at the time he goes out of practice.

ASPECTS OF THE REVISED LEGISLATIVE PROVISIONS.

ELIGIBILITY—Doctors, attorneys, dentists, farmers, ranchers, businessmen.

BASIC PHYSICIAN'S INVESTMENT—10% of your earned income, but not more than $2,500 before taxes.

EMPLOYEES TO BE INCLUDED—over three years continuous employment, at least 5 months a year, and 20 hours or more a week (the employees share receives the same tax shelter)

EXTRA, VOLUNTARY CONTRIBUTIONS—an extra $2,500 up to 10% of earned income may be made if you have an employee included under the plan. Employees also may make extra investment, but are not required to do so.

WITHDRAWAL OR VOLUNTARY CONTRIBUTIONS—these may be withdrawn at any time, but not the earnings on those monies.

FLEXIBILITY OF CONTRIBUTIONS—optional. Most profit sharing investment plans under Keogh provide for reduced payments in lean years.

RETIREMENT BENEFITS—may begin at 59½ years of age, but may also be postponed until 70½.

—may be made at any time in case you are disabled and if you die the funds in the plan are a non-taxable portion of your estate. Basic contributions and their related earnings may not be withdrawn before 59½, a distinct advantage in that your equity can not be diluted through use in speculative ventures or personal spending.

POSTPONEMENT PAST 70½—tax impact upon withdrawal may be postponed by reinvesting in new U. S. Government Retirement Bonds earning tax-free interest at 3¾%.

KEOGH PLAN ASSETS—are not attachable and not assignable. In case of bankruptcy, divorce, etc., these assets are inviolable.

EMPLOYED WIVES—if she really works for the doctor and he will pay her a salary, special advantages exist: Basic deductible investment is larger and both can make voluntary investment contributions to greatly increase the amount of investment funds brought under the tax umbrella.

SWITCHING INVESTMENTS—avialable through most fund Keogh approved plans, where a company manages more than one fund. At age 40 a D.O. may go into a growth fund and be permitted to switch at age 60 to a balanced fund, for a usual $5.00 administrative charge. (In private investing, he would have a capital gains tax to pay by redeeming one and buying into a new fund—under Keogh the switch is under a complete tax shelter.)

The entire matter of professional programs for investing retirement dollars in tax-sheltered plans will be examined in some depth at the national meeting of the Society of Divisional Secretaries, of which your Executive Secretary is vice-president, program chairman and a participant. Additional information will be available through the state association offices in Fort Worth shortly after the national convention.

Remember, NEWS from your district for the Journal must be in this office by the 20th of preceding month. Please give us your cooperation. THANKS!

Psychiatric Residency Training Program At Nevada State Hospital

The Division of Mental Diseases offically announced today the establishment of a psychiatric residency training program at the Nevada State Hospital. This was made possible through approval just received by the Kirksville Osteopathic Hospital, by the American Osteopathic Association through its American Osteopathic Board of Neurology and Psychiatry, and the AOA Committee on Hospitals.

This is a cooperative program with the Kirksville College of Osteopathy & Surgery for qualified osteopathic physicians, licensed by the State Board of Registration for the Healing Arts. The program is a career residency training program, extending over a five-year period and consisting of three years of active training, with an obligation for two years of service. The program is under the direction of Dr. Joe Combs, who occupies the new position of Director of Residency Training that was established through the cooperation of the Missouri Personnel Advisory Board. Full supervision of the program is by Fleda M. Brigham, D.O., FACN, Professor of Psychiatry at the Kirksville College of Osteopathy & Surgery.

Dr. Ulett pointed out that this program is the only one of its kind in the nation and that it is already underway, with the appointment of four well-qualified osteopathic physicians for residency training.

Editors Note: Dr. John P. Methner, a member of TAOP&S, formerly associated with Doctors Hospital, Groves, Texas, is one of the four Osteopathic physicians appointed for residency training.

Up to Twenty $1,500 Osteopathic College Scholarships

Offered By

The auxiliary to the American Osteopathic Assn.

Available To

Students Entering Osteopathic Colleges as Freshmen, Fall 1968

SCHOLARSHIPS will be sent to the osteopathic college at the rate of $750.00 for the first year and may be renewed the sophomore year provided the student has maintained satisfactory standards and his financial status has not changed.

REQUIREMENTS
*Good Scholastic Standing
*Financial need.
*Acceptance from one of the five approved osteopathic colleges listed below.
*Citizenship in the United States or Canada.

COLLEGES
*Chicago College of Osteopathy, 5250 Ellis Avenue, Chicago, Ill. 60615 College of Osteopathic Medicine and Surgery, 720-722 Sixth Ave., Des Moines, Iowa 50309.
*Kansas City College of Osteopathy and Surgery, 2105 Independence Avenue, Kansas City, Missouri 64124.
*Kirksville College of Osteopathy and Surgery, Kirksville, Mo. 63501.
*Philadelphia College of Osteopathic Medicine, Spruce St. at 48th, Philadelphia, Pennsylvania 19139.

Applications Must Be In Before May 1, 1968

Send Applications to

Office of
The Scholarship Chairman
212 East Ohio Street
Chicago, Illinois 60611

For Further Information

Write to the Dean of one of the five approved osteopathic colleges listed above or to Mr. Lawrence W. Mills, American Osteopathic Association, 212 E. Ohio Street, Chicago, Illinois 60611.

Osteopathic Resources Develop

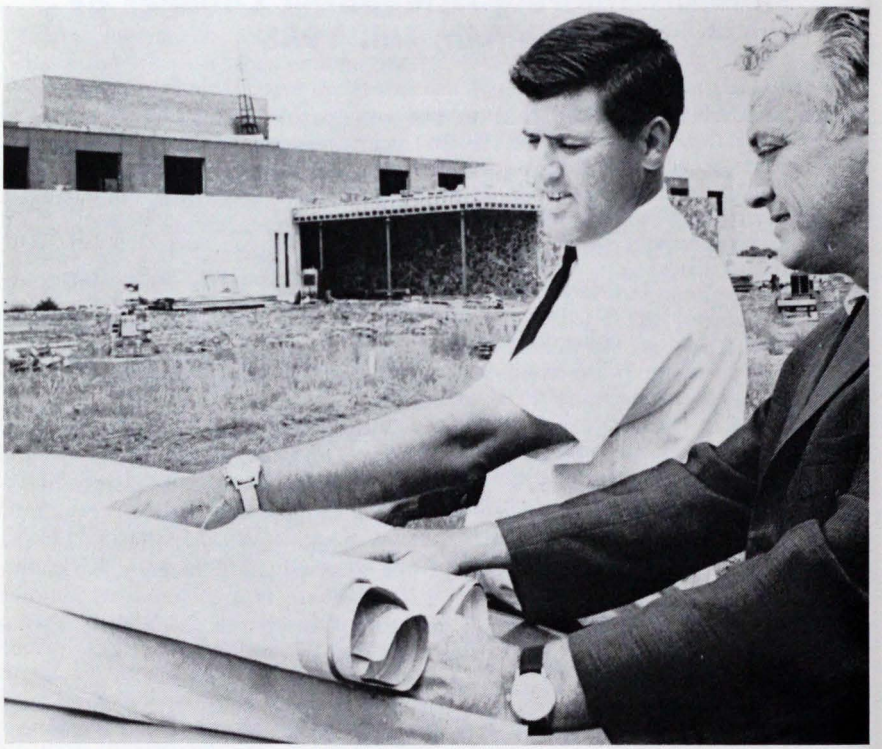
Hospitals — New and Expanding

Recent information from four different areas indicate that Osteopathic hospital facilities continue to be planned, built and expanded so as to better serve the DO-patient wherever in Texas that patient may require acute general hospital care.

Photographs of the new construction and details of ancillary facilities will be furnished the JOURNAL in the very near future.

* * *

New Amarillo Hospital a Reality



W. L. Davis, Jr., administrator, and Bradley Vosper, architect, . . . building on schedule

Construction of Hospital is to be Completed in January

Construction of the $1.5 million Amarillo Osteopathic Hospital at 2727 West 27th is on schedule and the staff will move into the new quarters by January 1.

The announcement of construction progress was made by W. L. Davis, administrator, who said the present facility at 801 West 10th had 110 per cent occupancy on Friday.

Davis said the new facility will have 67,000 square feet of space compared

with the present building's 16,000 square feet.

He estimated that operation of the new 58-bed hospital will require a 20 to 25 per cent increase in the number of employes. The present building has 36 beds and the census recently was 38 patients.

The administrator said the hospital had run at 92 per cent occupancy since Medicare was initiated on July 1, 1966. Prior to that time it averaged an 84 per cent occupancy, Davis said.

The board of directors has made no decision about disposition of the present building. It was constructed in 1942 as the first osteopathic hospital built exclusively as a hospital in Texas.

The board will receive $627,000 in Hill Burton funds for the new building.

William W. Collier Jr., a representative of the hospital division of the Texas State Department of Public Health, inspected construction of the new facility recently. His visit preceded the second payment of the federal aid. The first payment was made in April.

Under terms of the grant, the money was to be paid in four quarterly payments.

* * *

Joint-staff Institution For Commerce

In commerce, home of the 8,000 student East Texas State University campus, plans have been announced and construction has begun on a 35-bed acute general unit to be an open joint-staff between the DO and MD local physicians. DOs Patrick Martin and Kenneth White in joint venture with a local MD, his son who owns a convalescent home, and one private individual, have organized the new institution which will cost in excess of $240,000 when completed.

Major Expansion For Fort Worth Osteopathic

Plans have been finalized, working drawings are under preparation and the new $600,000 expansion project will soon be out for bids, according to Tom G. Leach, Administrator, Fort Worth Osteopathic Hospital. This federal participation project under the Hill-Burton Act was confirmed last summer for a major expansion to this Osteopathic teaching hospital and will involve both ancillary and acute patient care units said Leach, who is President-Elect of the Texas Osteopathic Hospital Association.

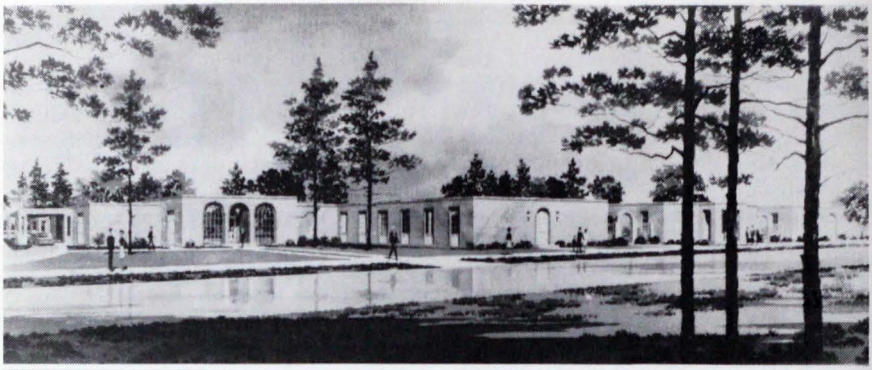
* * *

Eastway General (Houston) — Construction In Progress

Community Hospital Foundation, Inc. of Houston, Texas has begun construction of its new 115 bed Eastway General Hospital. The facility is located on an 8½ acre site at the vortex of a major expressway system in the northeast area of the city. The building is of one story, brick construction and features a Spanish modern motif. Future expansion will be accomplished by the construction of a multiple story wing housing 185 beds. The nursing facilities will be of one and two bedrooms, each with private bath.

The new plant will include three surgical rooms, cystoscopic room, recovery room, three diagnostic X-ray rooms, flouroscopic and isotope rooms, laboratory and physical therapy areas, and three emergency rooms. There is an obstetrics unit, nurseries, fathers waiting room and a pediatric play area.

Eastway General Hospital is scheduled to open on March 1, 1968 at which time the present plant will be converted to an extended care facility.



EASTWAY GENERAL HOSPITAL (artists concept) above

At Groundbreaking (left): Mr. C. E. Foster, Administrator, Dr. Cal J. Lyons, Vice President, Dr. Loren R. Rohr, President, Dr. William Masters, Chief of Staff (shown l. to r.)

Community Hospital Inc. was founded in 1951 as a 25 bed hospital by Dr. G. W. Tompson, Dr. Loren R. Rohr and Dr. Victor H. Zima. The plant was established at its present location—1405 Holland Avenue, Jacinto City, Texas. Four expansion programs increased the bed capacity to 60. In 1963 ownership was changed to a not-for-profit foundation known as Community Hospital Foundation, Inc. As a service to the community, and to the profession, the hospital has been active for many years as a training hospital—conducting programs for interns as well as Vocational nurses.

BROADWAY CLINIC
PHYSICIANS & SURGEONS
626 SOUTH BROADWAY
TYLER, TEXAS 75702

R. E. CORDES, D.O. C. B. BEATY, D.O. R. E. SLYE, D.O.

October 5, 1967

Mr. Robert B. Price, Editor
Texas Osteopathic Physicians Journal
512 Bailey Avenue
Fort Worth, Texas

Dear Bob:

I would like to submit this letter to the Journal for publication. This is in no way an attempt to by-pass the Liason Committee of the Texas Osteopathic Hospital Association, but I hope it can be added to their armamentarium and that it will give the AOA food for thought. Neither is it meant to be inflammatory.

The hour is late and at this time, a concerted, sincere effort is being made by our Texas hospitals to reach some sort of working agreement with the AOA. My opinion is that this is a "last ditch" effort. Most of us have worked hard to build and operate good hospitals. Attempts to communicate with the AOA with regard to deficiencies have resulted in rebuffs, double talk and complete uncertainty.

The following idea has entered my mind as a possible solution. Let the inspectors do their job as robots, reporting what they find, being totally devoid of personality, offering no help or suggestions, and discussing nothing with anyone. After the deficiencies have been tallied, send us a field man, who does have a personality and who will sit down and give us some help in correcting these short-comings by giving us a *correct* interpretation of the "brown book". The pat answer: "It's in the book", is about the most stupid reply that can be given. This is like saying: "It's in the Bible". Sure it is, but a multitude of denominations attest to the fact that there are numerous interpretations of the meaning of what is printed there.

I submit that the AOA has gotten us into a much worse situation by becoming our so-called accrediting agency. They are in no way equivalent to or analogous with the Joint Commission as an accrediting body, although they would lead one to believe that they are. This is not to say that we should seek accreditation by the Joint Commission, but until, or unless the AOA can be vested with the same authority as the Joint Commission, they should leave accreditation or approval of Osteopathic Hospitals to H.E.W. At the present, regardless of what the AOA might say, there are only two accrediting agencies, H.E.W. and the Joint Commission.

Our institution has every intention to correct our deficiencies as outlined by the AOA and we will do so, in the hope that we will then be accredited by them. This seems to be the attitude of the vast majority of all our hospitals in this great state. No one is asking for a "white-wash job" or a lowering of standards, but we do need a change of attitude. Should we fail in this sincere, honest attempt at cooperation, there are two other avenues open to us.

The entire purpose of this letter is to try to get someone to realize that a very definite problem and threat does exist in the State of Texas. So far the AOA has either turned a deaf ear or refused to admit that any threat exists.

Sincerely,
Bowden Beaty, D.O.

Announcing

• THE

Offered by — Texas Association

Available to — Texas Students ent

Requirements • Recommendation of Premedical Advisor
- Acceptance from one of the five approved osteopa
- Citizenship in the United States or Canada.

Colleges • Chicago College of Osteopathy, 5250 Ellis A 720-722 Sixth Ave., Des Moines 9, Ia. • Kansas City Kansas City 24, Mo. • Kirksville College of Osteopath Medicine, 48th and Spruce Sts., Philadelphia 39, Pa.

APPLICATIONS MUS

FOR FURTHER IN

TEXAS ASSOCIATION OF OST

512 Bailey Ave.

IL R. RUSSELL FRESHMAN SCHOLARSHIP
in the amount of $1,000.00

-:- AND -:-

750.00 TEXAS OSTEOPATHIC SCHOLARSHIPS

teopathic Physicians & Surgeons

Osteopathic Colleges as Freshmen

ttee • Good scholastic standing • Financial need
ges listed below • Interested in the osteopathic profession

ago 15, Ill. • College of Osteopathic Medicine & Surgery,
of Osteopathy and Surgery, 2105 Independence Ave.,
gery, Kirksville, Mo. • Philadelphia College of Osteopathic

I BEFORE APRIL 15

TION CONTACT

C PHYSICIANS & SURGEONS

Worth, Texas 76107

Accreditation Problems Dominate

Dr. G. Erle Moore Keynotes Successful Hospital Association State Convention

Annual educational sessions of Texas Osteopathic Hospital Association were stimulated by three active lecture and discussion appearances of Dr. Erle Moore, Director, Office of Hospital Affairs, American Osteopathic Association, in Dallas on August 11 and 12. W. Jack Dolbee, President, of Hurst General Hospital, was chairman throughout the meetings and Tom G. Leach, of Fort Worth Osteopathic Hospital, conducted the sessions as program chairman.

Attendance at the sessions varied from 45 to 80, according to the association secretary, Mrs. Grace H. Sharp, of East Town Osteopathic Hospital, and Mrs. Tom G. Leach who was in charge of registration.

Others connected directly with the profession who appeared at the speaker rostrum were Dr. Elmer C. Baum, Public Health Committee, Chairman of Austin, and Mr. Emil L. Herbert, Executive Secretary of the American College of Osteopathic Hospital Administrators, Park Ridge, Illinois. Additional expert speakers were furnished by the Texas Blue Plans and by workmens compensation carrier representatives.

The newly adopted and recently effective accreditation procedures and techniques were of extreme interest during the entire program, and Dr. Moore furnished much authoritative and basic information concerning the accomplishments, unexpected problems, and areas in which future progress could be expected.

A special ad hoc committee, chaired by Mr. John Isbell, Stevens Park Osteopathic Hospital, Dallas, and including President Dolbee and Dr. Robert H. Nobles, Denton, was appointed. This task force will accumulate all deficiency letters, inspectors reports and hospital rebuttals of Texas osteopathic hospitals that have been denied accreditation under the new program since January 1, 1967. These will be analyzed for common deficiency factors and possible errors or misconceptions between the inspection staff and the hospital administration, and codified where similarities appear to exist.

A conference between this group and the Hospitals and Insurance Committee of TAOP&S is anticipated, with a view toward a meeting of some representatives from both committees with the Committee on Hospitals of the A.O.A.

Since the convention, it has been learned that the Missouri Osteopathic

Hospital Association has petitioned the Board of Trustees of A.O.A. for a conference, citing the seriousness of the situation in that state concerning the hospitals in which a majority of general physicians do their acute general practice.

Officers elected for the subsequent year, to take office in May, 1968, were as follows:

President—T. G. Leach, Fort Worth Osteopathic Hospital, Fort Worth, Texas

President-Elect—Benny Bearden, Doctors Hospital, Groves, Texas

Vice President—Ollie Clem, Broadway Memorial Hospital, Tyler, Texas

Secretary-Treasurer—Grace Sharp, East Town Osteopathic Hospital, Dallas, Texas

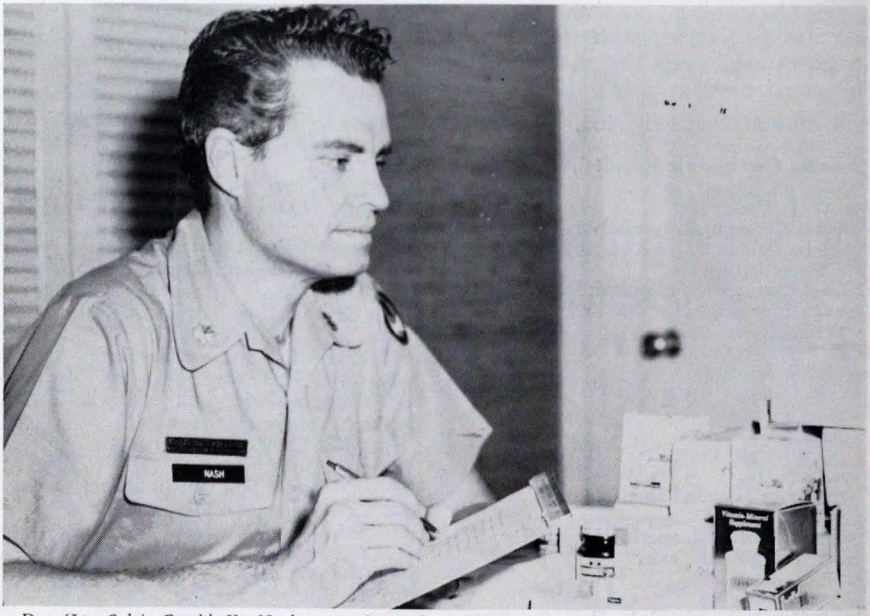
Board of Trustees—Dr. Glenn Scott —Amarillo Osteopathic Hospital, Amarillo, Texas and Dr. Seldon Smith, Wolfe City Hospital, Wolfe City, Texas

TOHA member hospitals for this year are as follows, with their representatives who were in attendance at the annual meeting:

S. B. Allen Memorial Hospital,
Bonham, Texas
Amarillo Osteopathic Hospital,
Amarillo, Texas
Mr. W. L. Davis, Jr.
Aransas Hospital, Aransas Pass, Texas
Mr. John Gilmor
Mrs. Kathy Gilmor
Capitol Osteopathic Hospital, Dallas, Texas
Doctors Memorial Hospital and Clinic,
Tyler, Texas
L. D. Lynch, D.O.
Bowden Beaty, D.O.
Mr. Olie Clem
Comanche Hospital, Inc.,
Comanche, Texas
W. A. Flannery, D.O.
Carolyn Smith
Community Hospital Inc., Houston, Texas
C. E. Foster
Corpus Christi Osteopathic Hospital,
Corpus Christi, Texas
D. H. Hause, D.O.
C. A. Housman
Crews Hospital and Clinic, Gonzales, Texas
Curry Clinic and Hospital,
Mt. Pleasant, Texas
Palmore Curry, D.O.
Dallas Osteopathic Hospital, Dallas, Texas
Frank E. Wells
DeKalb Clinic and Hospital,
DeKalb, Texas
Delgado Green Cross Hospital,
El Paso, Texas
Mrs. D. Leong, R. N.
Daniel Leong, D.O.
Denison Hospital and Clinic,
Denison, Texas
Doctors Hospital and Clinic—
Kennedale, Texas
Doctors Hospital, Tyler, Texas
Doctors Hospital, Groves, Texas
Marilyn Mobley
Gayle Morton
B. P. Bearden
N. G. Palmarozzi, D.O.
R. J. Shields, D.O.
Doctors Services Foundation,
Houston, Texas
E. J. Aycock
Denton Osteopathic Hospital,
Denton, Texas
O. C. Dill
East Town Osteopathic Hospital
Dallas, Texas
Fort Worth Osteopathic Hospital,
Fort Worth, Texas
T. W. Whittle, D.O.
Phil R. Russell, D.O.
Garland General Hospital, Garland, Texas
E. M. West
Dr. Jim Martin
Granbury General Hospital,
Granbury, Texas
L. G. Ballard, D.O.
R. C. Thomas
Gulfway General Hospital, Houston, Texas
Groom Memorial Hospital, Groom, Texas
J. M. Brooks
Hammond Hospital, Beaumont, Texas
Houston General Hospital, Houston, Texas
Mary Stukey
L. L. Larmore
Head of Elm Medical Center, St. Jo, Texas
Tom W. White
Hurst General Hospital, Hurst, Texas
Charles L. Curry, D.O.
Lake Worth Osteopathic Hospital,
Fort Worth, Texas
Lauf Clinic and Hospital, Lubbock, Texas
Lubbock Osteopathic Hospital,
Lubbock, Texas
Lee Baker
Leopold Osteopathic Clinic, Odessa, Texas
Mid-Cities Memorial Hospital,
Grand Prairie, Texas
H. M. Stewart, D.O.
J. Nat Stewart, D.O.
Mineola General Hospital, Mineola, Texas
J. Warren McCorkle, D.O.
James H. Love
Mims Memorial Osteopathic Hospital,
Comanche, Texas
Roy D. Mims, Sr., D.O.
Roy D. Mims, Jr., D.O.

Mt. Pleasant Hospital and Clinic, Mt. Pleasant, Texas
Nixon Clinic and Hospital, Nixon, Texas
Park Center Hospital, Euless, Texas
Charles Bell
Park Foothills Clinic and Hospital, El Paso, Texas
Plattner Clinic and Osteopathic Hospital, Grand Prairie, Texas
Porter Clinic and Hospital, Lubbock, Texas
J. N. Porter
G. G. Porter, D.O.
San Antonio Osteopathic Hospital, San Antonio, Texas
Everett Wilson, D.O.
Stevens Park Osteopathic Hospital, Dallas, Texas
Stratton Hospital and Clinic, Cuero, Texas
Talco Hospital and Clinic, Talco, Texas
E. L. Miller, D.O.
Mrs. E. L. Miller
Tigua General Hospital, El Paso, Texas
M. G. Holcomb, D.O.
White Settlement Hospital, Fort Worth, Texas
G. A. Fuller, Jr.
Wolfe City Hospital, Wolfe City, Texas
Seldon E. Smith, D.O.
Wintermute Memorial Hospital, Klondike, Texas
Guests attending TOHA Annual Meeting:
R. B. Price, Texas Association of Osteopathic Physicians and Surgeons
A. W. Vila, D.O., Yale Hospital and Clinic, Houston, Texas
Mr. and Mrs. C. W. Zahler, Yale Hospital and Clinic, Houston, Texas
Jane Hall
Jane Morgan — Physicians Hospital and Clinic, Stanton, Texas
Doris Montes
Lois Johnson
Pat Bell
Tina Martin
Mrs. Virginia Dean
C. Debard
John Mays—Mesquite General Hospital, Mesquite, Texas
Elmer C. Baum, D.O.
D. B. Whitehead, D.O., Trinity Osteopathic Medical Center, Carrollton, Texas
Harold Ersey

Operation Vitamin



Dr. (Lt. Col.) Gerald K. Nash, executive-medical officer, Group 1, Texas Wing-Civil Air Patrol, Amarillo, checks a shipment of medical supplies for DOCARE International, Inc. During the past five years Dr. Nash has collected and donatel, in the name of Civil Air Patrol, over 1-million medicinal tablets to welfare agencies caring for sick and needy Indians in the United States and Mexico. The project is called "Operation Vitamin."

In civilian life Dr. Nash is the Chief of Staff and Head of the Radiology Department of the Amarillo Osteopathic Hospital.

Trauma to the Bladder and Genitalia

CHARLES H. BRAGG, D.O., ACOS

INJURIES TO THE BLADDER

Contusions, punctures, extraperitoneal and intraperitoneal ruptures may result from trauma to the urinary bladder. Contusion is not often recognized clinically, but can be the cause of red cells found transiently in the urine. Of course, hematuria of some degree accompanies all significant vesical injuries. Perforation via the abdominal wall call for the general measures advised in the care of external wounds (tetanus prophylaxis, etc.) and especially for measures to prevent urinary extravasations into the local tissues or the peritoneum.

The insertion of a cystoscopy tube (occasionally through the wound itself) must always be favored as drainage by cystoscopy is the keystone to successful management of major injuries to the bladder. A transurethral catheter is also useful, but it is pertinent to realize that this irritates and obstructs the urethra and prostate, and thus aggravates infection, which a cystoscopy tube does not. In addition because of its larger caliber a cystoscopy catheter often functions better, particularly if clots and debris are present. Foreign bodies within the bladder should be removed at some convenient early time because they maintain infection and sooner or later tend to become incrusted into calculi.

The bladder rarely ruptures unless it is distended at the time of accident, and most are intraperitoneal in direction. It is important to know that a patient with a ruptured bladder may be able to pass some urine. A tendancy to shock and signs of lower peritoneal irritation appear promptly with large ruptures but may develop slowly if the leakage is not free. When rupture is suspected, gentle clean catheterization provides information concerning possible urethral damage and particularly permits a cystogram with one of the contrast media used for intravenous pyelography. The entrance of the contrast media into torn veins is quite common and accordingly only media tolerated intravenously are tolerated and advisable. Injection of air is conductive to embolism. Instillation of a certain quantity and measurement of the return constitutes a test so unreliable and often misleading as to make it at least useless. (for example, a rupture without free leakage will give a falsely favorable test, yet an intact organ with clots may provide an unfavorable test). If there is a good suspicion of vesicle rupture, cystostomy is indicated. The rent in the bladder should be simply sutured if at all feasible, but a large caliber cystostomy tube is the essential element in management. The incidence of additional intraperitoneal injuries is so great that at least a brief inspection there is nearly always advisable at the same time. Concerning cystostomies, it is better to do a few too many than a few too few and promptness excels procrastination! Of course, general supportive measures and antimicrobial drugs are valuable in the program. Extraperitoneal ruptures, while less common than the intraperitoneal, provide similar indications except that the physical findings tend to be more localized to the pelvic area. Sometimes extravasation can be felt by rectal examination (and evidences of other damage, such as urethral rupture, may come as a surprise). The extraperitoneal ruptures call for drainage, cystostomy, and general supportive measures. Injuries at surgery and

from irradiation have been considered as outside the scope of this chapter. The following general program should provide sufficient specific diagnosis of urologic injury to permit logical therapy. The history taking and physical examination may be done simultaneously in true emergencies, but concentration on first one and then the other is more conducive to accuracy. A history of previous genitourinary disorders may be of major importance, yet questions in this direction are too often forgotten in the rush. Included in the physical examination are the characteristics of the pulse, the blood pressure, and other observations relative to possibly developing shock; and the patient should be carefully observed from time to time in this regard as well as concerning the likelihood of possibly associated injuries. The patient should be asked to void and the speciman saved for urinalysis. Watching the patient void may provide useful information. For example, a prompt, large caliber, forceful, continous stream of grossly clear urine militates strongly against major urethral damage and partly against vesical rupture. A flat film of the abdomen is usually helpful and gentle catheterization is often indicated to test the urethra, obtain urine and permit cystography. Intravenous pyelography can hardly be over emphasized as a diagnostic tool. Cystoscopy and retrograde pyelography are reserved for specific indications — especially the indications that clearly needed information has not been obtained by the simpler and safer steps of the preliminary portion of the program. Developments may call for a change in plan of management at any time. Injuries to the male urethra from external or internal trauma may cause contusion, laceration, or rupture. The characteristic complications and sequelae injury depend on the location of the trauma. The triangular ligament is the dividing fascial plane between the anterior and posterior urethra. If, however, the ligament itself is torn, extravasation may proceed in either direction from either side of the ligament. The diagnosis of avulsion of the posterior urethra may be made from a history of severe injury often associated with fracture of the pelvis, bleeding from the urethra, pain in the lower abdomen with pain on gentle examination or pressure. Usually, the rectal examination reveals the prostate to be dislodged upwards in the pelvis and surrounded by boggy tissues infiltrated with fluid. It may be impossible to pass a catheter into the bladder. Injection of diluted intravenous contrast agent will demonstrate extravasation at the site of injury. Associated fractures of the bony pelvis are usually demonstrated on these films. The management of this injury calls for prompt treatment of associated shock and re-establishment of continuity of the urethra. The retropubic approach to the urethra with end-to-end anastomosis over a catheter is the ideal treatment. However, because of technical difficulties, this is rarely accomplished. Therefore, the usual procedure is to identify the severe

ends of the urethra by means of a retropubic exposure; pass a 24 French Foley catheter through the anterior urethra, guide it across the defect in the membranous urethra and inflate it in the bladder. Gentle traction applied to this catheter will appose the severed ends of the urethra. This approximation may be helped by passing mattress sutures on long straight needles from within the bladder out through the perineum and fastening them over folded gauze to provide traction. Cystostomy drainage is always advisable because of the frequent failure of urethral catheter drainage. Loose particles of bone should be removed, and the extravasated blood and urine evacuated. Adequate drainage of the retropubic area is important. Injury to the posterior urethra from internal violence is usually the result of instrumentation or electrosurgical procedures on the prostate. A physician usually causes these injuries and he should diagnose and treat them as soon as they occur. Laceration of the posterior urethra without loss of continuity is treated by drainage and urethral catheter. Simple contusion of the urethra may produce edema and so require a catheter. Injury to the urethra distal or anterior to the triangular ligament often results from internal or external violence. Internal injury in this part of the urethra is also usually caused by instrumentation. External trauma to the perineum as the result of straddle injuries compresses the bulb of the urethra against the symphysis pubis. If the injury is slight, the diagnosis is made from the history of injury and the presence of bleeding, which may be independent of urination or may be washed out with the urine. A soft catheter may be passed to the bladder if the continuity of the urethra is intact. The urethrogram is a diagnostic procedure. Toxic local anesthetics should not be injected into the traumatized urethra because of the danger of absorption. Death has followed the injection of procaine and similar agents into the injured urethra. The perineum, scrotum, and penis may become infiltrated with blood and urine. The diagnosis is made from the history of injury, bleeding from the urethra and swelling in the perineum, scrotum, or shaft of the penis. The swelling may increase with voiding as urine follows along the fascial planes. Anastomosis of the ruptured urethra should be carried out as soon as the condition of the patient will permit. This reduces the incidence and severity of stricutres.

TRAUMA TO THE GENITALIA

Serious injuries to the genitalia are uncommon in civilian life. The skin of the scrotum and penis may be avulsed when, for example, the clothes are caught in machinery. Prompt debridement and skin grafting is the best treatment of this injury. We have seen two cases of severe third degree burns of the genitalia from strong acids applied by outraged husbands while their paramourous victims were sleeping. In one of these, 3 cm. of the anterior urethra were burned away and eight plastic procedures were required to debride the necrotic tissues, graft the denuded areas and restore the continuity of the urethra. Injuries of the penis involving the corpora may cause severe bleeding. Ligation of the bleeding points is difficult, but pressure bandages applied from the meatus back to the base of the shaft with a catheter in the urethra to prevent its compression and urinary retention will control bleeding. Bleeding into the tunica vaginalis around the testes will produce a hematocele. This may be treated by compression dressing and injections of hyaluronidase, or if these measures are not effective, by surgical drainage.

L' Arte Medica

M. A. CALABRESE, D.O.

You will notice that with this edition comes a different photograph of yours truly. After many jibes from my office staff and hospital acquaintances (not to mention my charming wife, who always broke out in a dirty laugh every time she saw it) I was tactfully cajoled into using this more recent photograph which I was rather reluctant to do as it looks more like the father of the previous photo.

Just as I was beginning to think that my office staff and myself were the only people who read this column, I received two fine congratulatory letters. One was from Dr. George Northup, A.O.A. editor, whom I have admired for years for his dedication and courage in speaking out about our profession. The second letter was from Miss Sara Metcalf, secretary to the editor of T.A.O.P. & S. Journal. They were both great morale boosters.

Not too long ago I was browsing through a post graduate seminar catalogue. One of the courses offered was "Osteopathic Medicine", under which was described the structural diagnosis and treatment of lesions of the spine. Why is it that we preach to the world that Osteopathy, i. e. 'Osteopathic Medicine', is the most complete school of medicine but within our own ranks we relegate Osteopathic Medicine to structural diagnosis and manipulative therapy? When a D.O. does surgery, or writes a prescription, or gives manipulative therapy, or gives consultation, or delivers a baby, and keeps in mind the basic principles of Osteopathy, the unity and oneness of the human body, the inter-dependence of all his systems, the inseparableness of mind and body, and the driving force of the human body to normalize itself, isn't he practicing 'Osteopathic Medicine'?

This brings to mind another subject. Why the need for the structural diagnosis sheet that the A.O.A. Hospital Committee insists on having on all hospital charts? Are they really necessary? I ask this very sincerely. Of what value are they? Are they just there to show the medical hospitals that this is where our difference lies? Are we still self-conscious about our position? Aren't we confident enough yet that we still have to use some graphic chart to show that we're different? Isn't the D.O. degree enough to show that we are different and better? Doesn't the D.O. degree mean that we take into consideration the skeletal muscle system and give it its proper place in diagnosis and treatment? If we must show some evidence in our hospitals of being different from the M.D. hospitals, why don't we do something original with statistical verification? For instance, keeping account of the number hospital days for any one specific condition and showing that the patient in an Osteopathic Hospital has a shorter stay as compared to the stay in an allopathic hospital for the same condition with just as good if not better results. With this type of propaganda where just about everybody benefits—financially — insurance companies, patients, h o s p i t a l s, and employers, we could well justify our position as a separate, distinct, and most complete school of medicine.

I see according to an article written by Inez Robb, syndicated columnist of Scripps-Howard, that a different type of Medical School is being conducted in

Tuscon, Arizona, where a "new" concept is being taught to the students. Dr. Merlin K. Duval, dean of the new college of medicine, "believes that the whole man-the patient as an entity-has been lost sight of . . .". He goes on to say, "Our objective . . . is to give the student a broad view of medicine. Our students will look at the patient and *then* pin point his ailments and problems". Wow! This is new?

Miss or Mrs. Robb should be sent some Osteopathic literature. Further on in her column she makes reference to another medical college in Pennsylvania that " . . . carries a unique destinction. It is the first such institution to get its start by private subscription". Weren't all of our colleges started by private subscription, particularly from the practicing D.O.s in the field?

I'm sure all of you have had occasion to smile at a mispronounced medical word or term by a patient. I know I have had many but not until a few months ago have I been taking note of them and writing them down. Here are a few: The middle aged lady—"I had a 'hystermerectomy' six years ago doctor and I still have hot flashes." A young mother—"My other doctor told me I was 'anebic' and I want you to check my 'hebbie-globin' ". A young male teenager—"My knees were hurting yesterday and my mother said I got 'arcitis' ". More next time.

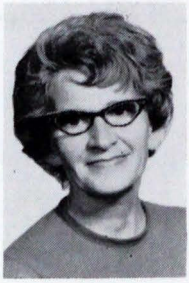
M. A. CALABRESE, D.O.

H. A. Beckwith, 1967 Program Chairman For The Annual Clinical Assembly Of O.C.O.O.

Harold A. Beckwith, D.O., San Antonio, Texas, a graduate of the Kirksville College of Osteopathy and Surgery is the 1967 Program Chairman for the 52nd Annual Clinical Assembly of the Osteopathic College of Ophthalmology and Otorhinolaryngology being held in San Francisco, California. The meeting will be October 30, 31 and November 1st meeting in conjunction with the 72nd Annual Clinical Assembly and Scientific Seminar of the American Osteopathic Association. Dr. Beckwith is Chairman of the Department of Ophthalmology and Otorhinolaryngology, San Antonio Osteopathic Hospital, ophthalmologist and otorhinolaryngologist at the Stratton Hospital and Clinic, Cuero, Texas and at Crews Hospital and Clinic, Gonzales, Texas. Dr. Beckwith has served as Chief of Surgery at the San Antonio Hospital. He is a member of the American Osteopathic Association, the Texas Association of Osteopathic Physicians and Surgeons and he is a Fellow and Diplomate of OCOO.

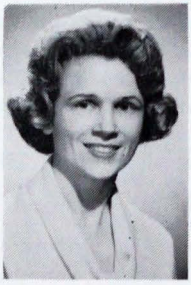
Whiskey — A drink that makes you see double and think single.

AUXILIARY OFFICERS 1967-68



MRS. HUGO J. RANELLE
President
Fort Worth, Texas

MRS. GEORGE J. LUIBEL
Immediate Past President
Fort Worth, Texas



MRS. R. G. HAMAN
President-Elect
Irving, Texas

MRS. CLAUDE H. LEWIS
Vice President
Ingleside, Texas

MRS. T. R. SHARP
Secretary
Dallas, Texas

MRS. BENJAMIN R. BEALL, II
Treasurer
Mineola, Texas

Where Are You?

Where are all the old members from last year? Our membership was 312 for the year 1966-67. This year to date we have 363 members. Out of this total only 227 ladies were with us last year. This means we have 136 new members which is just wonderful. *BUT*—Where are the 85 ladies who were with us last year and are not this year? *LADIES, WE WANT YOU!*

This is a special invitation to all those new wives who have done such a great job in Student Wives Association. *LADIES WE WANT YOU!*

This is a special invitation to those wives who were so active in the past and have fallen by the wayside. You are the ladies who made our Texas auxiliary what it is today, a group of which to be very proud. Help us to grow to higher heights than ever before. We need your knowledge and experience so very much. *LADIES, WE WANT YOU!*

Some of you may ask, "Why do we need you?" Here are just a few of the reasons: Your dues contribute to these funds; scholarship, student loan and research, osteopathic progress fund, and Still memorial fund. We want your name and address in print in our state yearbook. You receive the ATOPS newsletter and can read what other wives and their families are doing.

We provide for our state president to visit all our Districts. This ties us all together as one wonderful group, The Auxiliary to the Texas Association of Osteopathic Physicans and Surgeons.

This is all made possible by your dues. They are $5 for the regular member and $1.00 for those wives whose husbands are in their first year of practice. This $1.00 is for their national dues only and entitles her to state dues absoultely free the first year.

Doctors, pass this article on to your wives, wives, pass this article on to your non-members in your area so they can see what they are missing. If they want to pay their dues, just give to your district treasurer or send directly to me:

Mrs. Benjamin R. Beall, II
1033 Emily Lane
Mineola, Texas 75773

I hate to be one to repeat, but: *LADIES, WE WANT YOU!*

DUES PER DISTRICT FOR
1966-67 and 1967-68

District	1966-67	1967-68
I	24	21
II	65	84
III	10	26
IV	1	4
V	88	85
VI	45	53
VII	12	14
VIII	17	22
IX	9	10
X	18	17
XI	1	6
XII	7	8
XIII	13	13
	TOTAL 310	363
	+ 2	
	Honorary	

NEWS OF THE DISTRICTS

District No. Three

H. GEORGE GRAINGER, D.O.

Dr. Richard Cordes is President of the Tyler Gun Club. Every now and then they go out and shoot skeet. They're going to have a big skeet meet here in May, the paper says.

* * *

Cardiac Unit Demonstrated At Hospital

TYLER TEX.—A demonstration of the use of Broadway Memorial Hospital's heart monitor-pacemaker-defibcillator unit in cardiac emergencies was given nurses and staff doctors Tuesday at the osteopathic hospital's monthly staff meeting.

Dr. Bowden Beaty, connecting a simulated "heart patient" up to the electronic machine, explained its principles and its emergency use to the group. Dr. Beaty pointed out that it is not the doctor, but the nurses on duty (because they are there), who are most likely to be called upon to use it when a heart goes bad.

Nurses present were Betty Carson, R.N., Maxine Van der Beck, R.N., Pat Clem, L.V.N., Alien C r a f t, L.V.N., Dorothy McMullen, L.V.N., Nora Stewart L.V.N., and Edna Watkins, L.V.N.

Staff doctors attending were Drs. Burr Lacey, Quitman; John Turner, Canton; Robert Hamilton, Mabank; and Drs. K. E. Ross, L. D. Lynch, Robert Slye, Richard Cordes, Bowden Beaty and George Grainger, all of Tyler. Business Administrator Ollie Clem was also present.

It was announced that a film on heart resusitation, called "External C a r d i a c Massage," will be shown at the combined staff meeting in May.

Tyler's Dr. R. E. Cordes had his picture in the September-October issue of *Rx Golf & Travel.* He was over there in Savannah, Georgia, attending the inaugural event of the American Medical Skeet and Trap Association, held in connection with the National Skeet Shooting Championship meet. The picture shows him looking at the scoreboard with another medic from New York state.

* * *

Interesting genealogy of periennially youthful Dr. Jack Kennedy of Mt. Pleasant reveals a family tree from which hang 31 DO's!

Jack's grandfather Dr. Seth Yale Kennedy practiced in Palestine (Texas) in 1904. That was before there was a law here, even.

And a great aunt, Dr. Evelyn Walmsley, was the first woman DO to practice in New York City!

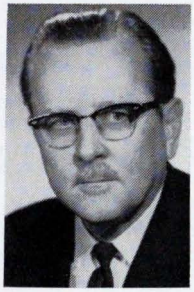
* * *

Dr. Bowden Beaty's father, Clyde, is recovering from a little heart attack he suffered June 10th. Looks as if it's gonna be a fine recovery. He was in Tyler's Broadway Memorial, and they were able to put their Monitor-Pacemaker-Defibrillator machine to good use.

* * *

Incidentally (and this ought to be big district news) Tyler's Broadway Memorial and Doctors Hospital are now one. No more wayward sheep. The plant out on the loop has been closed up, at least for the nonce, and we're all one big happy, crowded family, with beds in the hall. When the proper papers are finally duly signed and sealed "we" will be known as Doctors Memorial Hospital, and it looks like we better start lookin for a bigger place, too.

District No. Two



D D. BEYER, D.O., FACOP

Congratulations to Dr. Roy B. Fisher who recently was appointed as a member of the North Texas Planning Council for Hospitals and Related Health Facilities by the President, Robert L. Dillard, Jr. This council represents about ten counties in North Texas.

Captain Noel G. Ellis, Jr., son of Drs. Noel and Virginia Ellis, was home on a short furlough before leaving for survival training in the State of Washington. He will then be flying in the F4D Phantom planes. He will later be stationed in Thailand.

The Public Health Committee of District Two will hold a meeting in the near future to discuss setting a dinner date for our state senators, representatives and their wives in this area. We feel that we should get better acquainted with the men who represent us in Austin. This dinner meeting has the unequivocal and financial support of District Two. Of course, politics are out of your reporter's line but we will do our best.

District No. Four

ALLEN M. FISHER, D.O.

Little seems to happen in this, one of the largest geographical districts in Texas. In fact, in common with business as a whole, our people have been much too healthy this year. This reporter is going to put himself in the class of strangers and fools and presage a cold, wet winter.

An interesting meeting was held recently in Stanton, Texas with six out of ten doctors present. Dr. W. D. Kelley, an orthodonist from Midland, Texas, was the speaker and presented a program of "Diagnosis and Treatment" of cancer through biochemistry and natural diet. A question-and-answer session revealed the interest this subject engendered and much was discussed that was of personal experience and individual thinking apart from present literature and hide-bound theories.

Our president, Dr. Wiley Rountree of San Angelo, was not able to be present at the meeting but we are making sure of him for the next, in San Angelo, having him present the program.

Gourley Fund for Osteopathic Education & Research

A Lawrence L. Gourley Memorial Fund for Osteopathic Education and Research is being established. This fund will be deposited within The National Osteopathic Foundation. Contributions are solicited and checks should be made payable to The National Osteopathic Foundation and designated that such funds are for the Lawrence L. Gourley Memorial Fund.

NOTICE OF EXAMINATION

The next meeting of the Texas State Board of Medical Examiners when Examinations will be given and Reciprocity applications will be considered is scheduled for December 4, 5, 6, 1967, at the Hotel Texas, Fort Worth, Texas.

Completed examination applications for applicants who graduated from United States medical schools must be filed with this office thirty days prior to the meeting date.

Completed examination applications who graduated from foreign medical schools must be filed sixty days prior to the meeting date.

Complete reciprocity applications must be filed sixty days prior to the meeting date to be given consideration.

TEXAS STATE BOARD OF MEDICAL EXAMINERS
1612 Summit Ave. — Suite 303
Fort Worth, Texas 76102

CALENDAR OF EVENTS

Oct. 30-Nov. 2—AMERICAN OSTEOPATHIC ASSOCIATION, 72nd Annual Convention and Scientific Seminar; Fairmont, Mark Hopkins, Sheraton-Palace Hotels, Del Webb's Townehouse, San Francisco. Program chairman, Dr. Dana P. Arneman, 6265 Sodum-Hutchings Road, Girard Ohio 44420.

Dec. 1-2—POST-GRADUATE SEMINAR OF THE TEXAS STATE DEPARTMENT OF HEALTH. Statler-Hilton Hotel, Dallas, Texas.

Feb. 24-25, 1968—TEXAS ACADEMY OF APPLIED OSTEOPATHY, Dallas, Texas. Laura A. Lowell, D.O., 4153 Travis, Dallas, Texas, 75204.

May 6-7 — BOARD OF TRUSTEES, TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, ANNUAL MEETING, Shamrock Hilton Hotel, Houston, Texas. Wiley B. Rountree, D.O., President, 19 North Irving, San Angelo, Texas.

May 8—HOUSE OF DELEGATES, TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, ANNUAL MEETING, Shamrock Hilton Hotel, Houston, Texas, Samuel B. Ganz, Speaker of the House, 3902 Highway 9, Corpus Christi, Texas.

May 9-11—TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, ANNUAL CONVENTION. Shamrock Hilton Hotel, Houston, Texas. R. B. Price, Executive Secretary, 512 Bailey Avenue, Fort Worth, Texas.

May 11—NEW BOARD OF TRUSTEES, TEXAS ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS. Shamrock Hilton Hotel, Houston, Texas.

PROFESSIONAL CARD DIRECTORY